OLR Bill Analysis

HB 7001

Emergency Certification

AN ACT CONCERNING DEFICIT MITIGATION FOR THE FISCAL YEAR ENDING JUNE 30, 2013.

SUMMARY:

This bill reduces appropriations for state programs and purposes and transfers money from special funds and accounts to the General Fund to address the projected deficit for FY 13. The bill makes changes affecting a variety of topics, such as hospitals and medical assistance programs, charter schools, and longevity payments for nonunion state employees. A section-by-section summary appears below.

EFFECTIVE DATE: Upon passage, unless otherwise noted below.

§ 1 — REDUCED APPROPRIATIONS FOR FY 13

The bill authorizes the Office of Policy and Management (OPM) secretary to reduce FY 13 allotments to various agencies by a total of $210,540,125. It also allows him to reduce FY 13 allotments to the Special Transportation Fund by $7,414,380. This has the effect of reducing the amount that agencies can spend in the remainder of FY 13 to achieve budget savings.

Please see the fiscal note for a detailed explanation of these reductions.

§ 2 — MOSQUITO SURVEILLANCE PROGRAM

By law, the Connecticut Agricultural Experiment Station must survey and test for mosquitoes carrying the eastern equine encephalitis virus according to a plan developed and agreed to by its director and the commissioners of energy and environmental protection and public health. The bill specifies that it must do this within available appropriations.

§ 3 — PRIOR AUTHORIZATION FOR THERAPIES

The bill requires the Department of Social Services (DSS)

commissioner to establish, by regulation, prior authorization (PA) procedures for physical, occupational, and speech therapies for Medicaid participants. The department's regulations already cover these services when the level of care exceeds department thresholds. For example, PA is required for physical therapy services that exceed an initial evaluation and twice-weekly visits.

The bill allows the commissioner to implement necessary policies and procedures while in the process of adopting regulations, so long as he publishes notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days after implementing the interim policies and procedures.

§§ 4-7 — MEDICAID TRANSITION TO ADMINISTRATIVE SERVICES ORGANIZATION MODEL

PA 10-179 authorizes DSS to replace its Medicaid fee-for-service and managed care models with one overseen by an administrative services organization (ASO) (dental and behavioral health services were excluded). It permits the department to annually modify rates for (1) outpatient hospital (clinic and emergency room); (2) blended, inpatient; (3) home health and homemaker home health aide; and (4) medical provider services (the department need not examine medical provider rates annually). The department can do this if needed to ensure (1) patient access or (2) that implementing the ASO model will not cost the Medicaid Program more than it would without the change (i.e., be "cost-neutral"). Although traditional Medicaid cost calculations take into account how often a particular service was provided ("utilization"), the act specifically excludes this factor from DSS' cost-neutrality analyses. The bill permits the department to take utilization into account during FY 13 and does not specify if it may be counted in future years.

Background

Converting Medicaid Program to ASO Model. PA 10-179 authorizes DSS to contract with one or more ASOs to provide a variety of nonmedical services for Medicaid, HUSKY A and B, and Charter Oak Health Plan enrollees. DSS previously contracted with managed care organizations to perform most of these services, which they did as part of a risk-sharing capitation payment that covered medical services. ASOs perform the services for a set fee and do not share any risk for the provision of medical services.

§ 8 — CUSTOMIZED WHEELCHAIRS FOR MEDICAID RECIPIENTS

The bill expressly provides that customized wheelchairs are covered under the state Medicaid plan, but only when DSS determines that a standard wheelchair will not meet an individual's needs. This equipment is already covered, but the department does not currently have sole discretion to determine if it is appropriate in a particular case.

In making this change, the bill appears to override existing Medicaid procurement policies for (1) nursing facilities (skilled nursing homes, rehabilitation facilities, and residential care homes), (2) intermediate care facilities for people with mental retardation ("ICF/MR" — group homes) and (3) people living in the community.

The bill also (1) authorizes the department to review and require pre-approval of repairs and parts replacement for all wheelchair types and (2) directs that refurbished wheelchairs, parts, and components be used whenever practicable.

Wheelchairs for Those Living in Nursing and ICF/MR Facilities

Current DSS regulations obligate the above-described facilities to identify Medicaid-eligible residents who may need customized wheelchairs (chairs custom-made for people who cannot independently maintain proper body alignment and position using a standard wheelchair). When a resident appears to meet the criteria, facilities must assign a multi-disciplinary team of health care providers to conduct a needs assessment and determine what, if any, wheelchair adaptations the resident needs. The bill prohibits facilities and vendors from assessing a Medicaid recipient's wheelchair needs unless the department specifically asks them to do so.

Wheelchairs for Those Living in the Community

The regulatory procurement process for non-institutionalized Medicaid recipients is initiated with a written prescription and documentation of medical necessity. As with facility residents, the bill prohibits vendors from conducting needs assessments for this group unless DSS makes a specific request.

Regulations

The bill authorizes the DSS commissioner to adopt necessary implementing policies and procedures while in the process of adopting them as regulations. The bill directs him to publish notice of his intent to adopt regulations in the *Connecticut Law Journal* no later than 20 days after implementing them.

§ 9 — HOSPICE SERVICE RATE REDUCTION

The bill imposes a temporary 5% reduction on Medicaid reimbursement rates for long-term care facility residents receiving only hospice care. DSS will pay facilities the lower per diem from January 1, 2013 through June 30, 2013.

Some long-term care facility and hospice agency services provided to residents who have chosen hospice care overlap. In this situation, federal Medicaid law allows state programs to set a facility's per diem rates at 95% of what it would otherwise have been.

§ 9 — CHIROPRACTIC COVERAGE FOR MEDICAID RECIPIENTS

The bill requires the DSS commissioner to amend the Medicaid state plan to limit chiropractic coverage only to the extent required by federal law.

Federal law provides that chiropractic coverage is an optional service for adult Medicaid recipients and the state does not currently cover this for adults if the service is provided by an independent chiropractor. (The state's program will pay if the service is provided in a hospital clinic and at certain federally qualified health centers.)

Federal law generally requires that children under age 21 be entitled to receive chiropractic coverage under the Medicaid's Early and Periodic Screening, Diagnostic, and Treatment provisions if ordered by a medical professional to treat a condition that a screening reveals. The state reimburses independent chiropractors treating Medicaid-eligible children.

§ 10 — FEDERALLY QUALIFIED HEALTH CENTERS

Federally qualified health centers (FQHC) are community-based clinics that provide primary and preventive health care services to "medically underserved" populations or areas without regard to a patient's ability to pay. Medicaid reimbursements are a major source of FQHCs' funding and must, by law, be based on a center's actual costs. Cost reports, backed up by audited financial statements, provide the financial information DSS needs to determine if an FQHC's Medicaid rates are too high or too low.

Under the bill, centers must annually provide DSS Medicaid cost reports and financial statements for the previous state fiscal year, along with any other information the department reasonably requires. The first filing is due by February 1, 2013, and subsequent filings are due

each January 1 thereafter. Although neither is currently required in statute, DSS does require FQHCs to provide this information annually.

Changes in Projects' or Services' Scope

Federal public health grants are also a large source of FQHCs' operating funds. In many cases, centers must submit an initial scope of work with their grant applications, describing how they will use any funds awarded. They must inform the funding agency (usually the Health Resources and Services Administration (HRSA)) and get its approval before changing an existing project's scope

By an unspecified date, the bill also requires FQHCs to give DSS copies of their original, HRSA-approved scope of project descriptions and all approved amendments. Going forward, centers must give the department written notice and copies of any new federally approved amendments within 30 days of approval.

The bill also requires FQHCs to notify DSS in writing of increases or decreases in the scope of services they provide within 30 days of the change. If DSS requests additional information, centers must provide it within 30 days of the request.

Rate Adjustments

The bill authorizes DSS to use the method specified in federal Medicaid law to raise or lower an FQHC's "encounter" rate based on the department's review of its (1) Medicaid cost report and audited financial statement, (2) federally approved initial or amended scope of project documents, or (3) written notice of increases or decreases in the type of services it is providing.

Penalties

The bill authorizes the DSS commissioner to fine an FQHC $500 for each day its reports or responses are more than 30 days overdue.

Regulations

The bill authorizes the commissioner to implement necessary policies and procedures, provided he publishes notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days after he has implemented them.

§§ 11-13 — INTERDISTRICT MAGNET SCHOOL TUITION

This bill extends the interdistrict magnet school tuition requirement and related provisions to pre-kindergarten. Current law does not give

specific authority to charge tuition for pre-kindergarten.

By law, a sending school district may be charged tuition for students from its district who attend K-12 classes at an interdistrict magnet school operated by a regional education service center (RESC). The bill extends this requirement to pre-kindergarten classes.

The law authorizes the magnet school to charge tuition in an amount equal to the difference between the average per pupil expenditure of the magnet school for the previous fiscal year and the per pupil state magnet school grant plus any revenue from other sources. Under law, Hartford school district-operated magnet schools are prohibited from charging tuition, with the exception of the Great Path Academy that Hartford operates on behalf of Manchester Community College. The bill extends this prohibition, along with the Great Path exception, to pre-kindergarten programs.

It also makes a conforming change.

§§ 14-21, 27, 29, 30, & 38— TRANSFERS TO THE GENERAL FUND FOR FY 13

The bill transfers available balances from various agency appropriations, special funds, and non-appropriated accounts to the General Fund to be counted as General Fund revenue for FY 13. It does the same for any remaining balance in the boating account and fuel oil conservation account. The amount transferred from each appropriation, fund, or account is listed in Table 1 below

Table 1: Transfers to FY 13 General Fund Revenue

§	*Agency*	*Fund/Account*	*Amount*
14	Office of Higher Education	Capitol Scholarship Program	$236,117
15	Office of Policy and Management	Regional Performance Incentive Account	$7,500,000
16	Department of Banking	Banking Fund	$1,200,000
17	Workers' Compensation Commission	Workers' Compensation Administration Fund	$450,000
18	Public Utilities Regulatory Authority	Consumer Counsel and Public Utility Control Fund	$2,300,000
19	Insurance Department	Insurance Fund	$500,000

20	Department of Energy and Environmental Protection	Boating Account	Any remaining balance
21	Comptroller	Fuel Oil Conservation Account	Any remaining balance
27	Department of Motor Vehicles	School Bus Seat Belt Account	$4,700,000
29	Public Utilities Regulatory Authority	Public, Educational, and Governmental Programing and Education Technology Investment Account	$3,600,000
30	Department of Public Health	Biomedical Research Trust Fund	$2,000,000
38	Department of Economic and Community Development	Statewide Marketing	$2,000,000

§ 22 — DSS REIMBURSEMENTS TO PHARMACIES

The bill reduces, from $2 to $1.70, the amount of the dispensing fee that DSS pays pharmacists for each prescription they fill for beneficiaries of DSS pharmacy assistance programs (e.g., Medicaid).

The bill also increases, from 14% to 15%, the amount of discount off the average wholesale price (AWP) DSS pays independent pharmacies for filling brand name prescriptions, subject to federal approval. Under PA 12-1, June Special Session, and contingent upon federal approval, DSS must reimburse independent pharmacies for dispensing these drugs to Medicaid recipients at AWP minus 14%. Chain pharmacies continue to be paid at AWP minus 16%.

§ 23 — TRANSFER OF FUNDS TO THE SPECIAL TRANSPORTATION FUND

The bill reduces, by $7,414,000, the amount of money the comptroller must transfer from the General Fund to the Special Transportation Fund in FY 13. Under current law, he must transfer $102,659,000; the bill requires him to instead transfer $95,245,000.

§ 24 — DEPARTMENT OF CHILDREN AND FAMILIES (DCF) PLACEMENTS OF CHILDREN WITH CAREGIVERS

The bill subjects certain caregivers (i.e., relatives, nonrelatives if the child's sibling who is related to the caregiver is also placed with that caregiver, or a special study foster parent) with whom DCF places a child to agency licensure. Currently, these children, who have been removed from their parents' custody and placed with DCF temporarily, can be placed with these caregivers for up to 90 days

without a license; after that, they are subject to licensure. The bill does not specify a deadline by when licensure must occur.

By law and unchanged by the bill, these placements can be made only when it is in the child's best interests. Additionally, DCF must conduct a satisfactory home visit and a basic assessment of the family, and the intended caregiver must attest that any adult living within the household has not (1) been convicted of a crime or (2) arrested for (a) a felony against a person; (b) injury or risk of injury to or impairing the morals of a child; or (c) the possession, use, or sale of a controlled substance.

As a conforming change, the bill eliminates a requirement that the commissioner adopt regulations for certifying these unlicensed caregivers.

Under federal law, states may claim administrative costs on behalf of otherwise eligible children placed in an unlicensed or unapproved relative home for the lesser of 12 months or the average length of time it takes to license or approve a foster family home. States are prohibited from claiming administrative costs for a child placed in an unlicensed foster family home that is not related to the child.

§§ 25 & 26 — STRETCHER VANS FOR CERTAIN MEDICAL ASSISTANCE PATIENTS

The bill provides that DSS regulations may authorize payment only for the mode of transportation that is medically necessary for anyone covered by one of its medical assistance programs. Current DSS regulations allow for the least costly, most appropriate mode of transportation for someone when needed to obtain medically necessary services.

The bill further provides that notwithstanding DSS medical assistance and Department of Public Health (DPH) emergency services laws to the contrary, if any of these recipients (1) requires nonemergency transportation, (2) must be transported in a prone position, and (3) does not require medical services during transport, he or she may be transported in a stretcher van. The DSS commissioner must establish Medicaid rates for these rides. A stretcher van is a vehicle, such as a modified van, that is capable of accommodating a stretcher for transporting individuals who cannot sit up.

The bill requires the Department of Transportation (DOT), in consultation with the DPH commissioner, to adopt regulations to

establish oversight of stretcher vans as a livery service requiring a DOT permit. The regulations must prescribe safety standards for the vans including a requirement that an attendant, in addition to the driver, accompany anyone transported in them. Current DOT regulations require only that livery permit holders ascertain that any driver they employ holds a public service operator's license and is fully instructed in the state's motor vehicle and livery laws (Conn. Agency Regs., § 16-325-6).

The bill also eliminates a requirement that any person operating a vehicle other than an ambulance, rescue, or management service vehicle have a DPH license or certificate in order to transport patients on stretcher.

§ 28 — MUNICIPAL VIDEO COMPETITION TRUST ACCOUNT

The bill reduces, from $5 million to $1.5 million, the maximum FY 13 deposit into the municipal video competition trust account. Under current law, the comptroller must deposit into the account up to $5 million each fiscal year from the gross earnings tax on certified competitive video service providers (i.e., certain cable TV companies).

§ 31 — CHARTER SCHOOL PER-STUDENT GRANT REDUCTION

The bill reduces the state's FY 13 per-student grant for charter schools by $300, from $10,500 to $10,200. It keeps intact scheduled increases for FY 14 to $11,000 and for FY 15 and subsequent years to $11,500. It also makes the conforming change that the last quarterly payment from the state in FY 13 may be adjusted pro rata for each student.

A charter school is a public school organized as a nonprofit corporation and operated independently of a local or regional board of education.

§§ 32-37 — LONGEVITY PAY FOR NONUNIONIZED STATE EMPLOYEES

The bill eliminates longevity pay for nonunionized state employees whose pay and longevity are not stated in statute and, beginning July 1, 2013, increases the pay of the affected employees by the annualized amount of their April 2013 longevity payment.

It makes the April 2013 payment the last longevity payment for:

1. managerial, confidential, and classified and unclassified

employees of the executive branch, constituent units of higher education, and the Board of Regents for Higher Education;

2. Judicial Department employees; and

3. legislative employees.

It specifies that the last longevity payment is based on the employee's longevity service as of September 1, 2011. It bans longevity payments to any nonunionized state employee who does not have his or her pay and longevity stated in statute, for service completed on and after April 1, 2013.

Nonunionized state workers can be divided into two groups, one that has pay and longevity specifically stated in statute and the other that has pay and longevity authorized under broader statutory authority of an administrative body of the state. The bill affects those employees under the various administrative bodies of the state. It does not affect judges, workers' compensation commissioners, chief and deputy state's attorneys, chief and deputy public defenders, the probate court administrator, and family support magistrates who all have their salaries and longevity schedules set in statute.

Eliminating Longevity Payments

Under current law, longevity pay is given twice a year to state employees who have served the state for at least 10 years. The amount of the payment increases at five-year steps — 15, 20, and 25 years — until the employee has reached a maximum for the formula for his or her position.

The bill requires the administrative bodies of each branch of state government and the Division of Criminal Justice to eliminate longevity payments for state service completed on or after April 1, 2013.

The bill supersedes the administrative authority of the relevant administrative bodies to establish longevity schedules as follows:

1. Administrative services commissioner and Office of Policy and Management secretary — CGS § 5-200(p),

2. Chief court administrator and Supreme Court Justices — CGS § 51-12, and

3. Division of Criminal Justice — CGS § 51-279,

4. Legislative Management — any general statute provisions.

The bill requires the last longevity lump sum payments to be made on the last regular pay day in April 2013. It specifies that the last longevity payment is based on the employee's longevity service as of September 1, 2011.

It also makes conforming changes, including permitting those who retire between October 1, 2012 and March 31, 2013 to receive a prorated longevity payment based on the proportion of the employee's six-month period served before retirement.

The bill requires an annual salary increase for each non-union employee who (1) received a longevity payment in April 2011 and (2) does not have his or her salary stated in statute. The increase must be the annualized amount of the longevity payment paid on the last regular pay day of April 2013.

§ 39 — LAPSES

The bill allows the OPM secretary to recommend the following reductions in FY 13:

1. $2.5 million in executive branch expenses,

2. $1.5 million in executive branch expenses for personal services,

3. $2 million in legislative branch expenditures, and

4. $5 million in judicial department expenditures.

The six legislative leaders must determine how the legislative reductions are achieved. The chief justice and chief public defender must determine how the judicial reductions are achieved.

§§ 40 & 41 — STEM CELL RESEARCH FUND FINANCING

The bill eliminates the transfer, in FY 13, of $10 million from the Tobacco Settlement Fund to the Stem Cell Research Fund, instead transferring this money to the General Fund. Under current law, the transferred money must be used to provide grants to eligible institutions to conduct embryonic or human adult stem cell research.

The bill authorizes the issuance of up to $10 million in state bonds for the same purpose.

EFFECTIVE DATE: Upon passage for the transfer provision and January 1, 2013 for the bonding provision

§§ 42 & 43 — INSURANCE PREMIUM TAX CREDIT LIMIT

For the 2012 calendar year, the bill lowers, from 55% to 30%, the amount by which an insurer can reduce its annual insurance premium tax liability through film production and film infrastructure tax credits.

Existing law (1) classifies insurance premium tax credits into three types, (2) specifies the order in which an insurer must apply the three credit types to offset liability, and (3) establishes the maximum liability that an insurer can offset in calendar years 2011 and 2012 by claiming one or more of these types of credits.

Under current law, the three credit types and the maximum tax reduction from each type are:

1. Type 1: film production, film infrastructure, and digital animation credits, 55%

2. Type 2: insurance reinvestment fund credits, 70%

3. Type 3: all other credits, 30%

The bill moves film production and film infrastructure tax credits from Type 1 to 3, thus allowing an insurer to use these credits to reduce its 2012 premium tax liability by up to 30%, rather than 55%. In doing so, it also changes the order in which insurers apply film production and film infrastructure credits to offset liability (see BACKGROUND).

As under existing law, for 2011 and 2012, an insurer may offset additional tax liability by an amount equal to $6,000 multiplied by its average net monthly increase in employees, up to 100% of its total tax liability.

The bill also protects insurance premium taxpayers affected by the lower credit limit for the 2012 calendar year from interest penalties for any underpayment. The law generally requires insurance premium taxpayers to pay estimated taxes in quarterly installments of 30% for the first quarter, 30% for the second, 20% for the third, and 20% for the fourth. If the company underpays any installment, the law requires it to pay interest of 1% per month on the underpayment.

Background

Application of Insurance Premium Tax Credits. The law specifies the order in which an insurer must apply the three credit types to offset liability as follows:

Credit Types Claimed	*Order of Applying Credits*	*Maximum Reduction In Tax Liability*
Type 3	None	30%
Types 1 & 3	1. Type 3 2. Type 1	Type 3 = 30% Sum of two types = 55%
Types 2 & 3	1. Type 3 2. Type 2	Type 3 = 30% Sum of two types = 70%
Types 1, 2, & 3	1. Type 3 2. Type 1 3. Type 2	Type 3 = 30% Type 1 + Type 3 = 55% Sum of all types = 70%
Types 1 & 2	1. Type 1 2. Type 2	Type 1 = 55% Sum of two types = 70%

§ 44 — TRANSFERS

The bill transfers $2 million from the community investment account (CIA) to the General Fund as revenue for FY 13. It requires that the account's remaining revenues be distributed as required by current law. Under current law, $10 of each fee credited to the CIA must be deposited in the agricultural sustainability account. The remainder of the revenue is split among the departments of Economic and Community Development, Energy and Environmental Protection, and Agriculture, and the Connecticut Housing Finance Authority, for specified purposes.

§ 45 — NEWTOWN SCHOOL YEAR

Current law allows the State Board of Education (SBE) to shorten the school year (which must be at least 180 school days) due to an unavoidable emergency. The bill requires the SBE to allow a shorter 2012-2013 school year in Newtown if its school board requests this.

§ 46 — HEALTH CARE COST CONTAINMENT COMMITTEE

This bill requires Health Care Cost Containment Committee (HCCCC) members who represent the state, in consultation with the state comptroller, to propose that the committee review prescription claims data from active and retired state employee healthcare plans for ways to increase generic prescription use under the terms established by the State Employees Bargaining Agent Coalition (SEBAC) agreements.

The HCCCC has 17 members: eight represent state management interests and are appointed by the governor, eight represent state employee interests and are selected by the SEBAC unions, and one neutral representative is jointly selected by the management and labor representatives.

Among other things, the 2009 SEBAC agreement created a three-tiered medication copay system, with employees paying $5 for generic medications, $10 for preferred name brands, and $25 for non-preferred name brands. The 2011 agreement maintained $5 copays for all generic drugs, but for non-maintenance medications, it increased co-pays for preferred name brand drugs from $10 to $20, and for non-preferred name brands from $25 to $35.

§ 47 — FUNDING FOR MUNICIPAL BUILDING AND SCHOOL SECURITY SYSTEMS

The bill makes municipal improvements to building security systems, including schools, eligible for funding under the Local Capital Improvement Program (LoCIP) Fund.

LoCIP, administered by the Office of Policy and Management, reimburses municipalities for the cost of eligible local capital improvement projects, such as road, bridge, and public building construction activities. OPM annually allocates LoCIP funds to municipalities according to a statutory formula (CGS §§ 7-535 *et seq*.).

§ 48 — JUVENILE DCF COMMITMENT

The law requires a juvenile court to commit a child convicted as delinquent to DCF if the court finds that its probation or other services are inadequate for the child. The bill eliminates the requirement that the juvenile court consult with DCF to determine the placement that would be in the child's best interest prior to making such a commitment.

The law also allows the juvenile court to order a child convicted as delinquent and committed to DCF to be placed directly in a contractual

residential facility in Connecticut. The bill requires the juvenile court to consult with DCF prior to ordering such a placement.

EFFECTIVE DATE: Upon passage and applicable to commitments and orders entered on or after that date.